Virginia PRE-ADMISSION *Screening*
Mental Retardation and/or Related Condition Level II Instrument

SECTION I: IDENTIFICATION

1. Name: _____ _____ _____
Last First MI

2. Gender: ☐ M ☐ F 3. DOB: _____ 4. Age: _____

5. Private Pay ☐ No ☐ Yes 6. Medicaid #: _____ 7. SSN: _____

8. CSB Name: _____ 9. Evaluation date: _____
(Catchment area)

10. Evaluation location: ☐ NF ☐ Hospital ☐ Home ☐ Other (*specify*): _____

11. LPASC: Contact person: _____
(Title)
Address: _____ City: _____ State: _____ Zip: _____

Telephone: ( ) _____

12. Per documentation in chart, does the individual have a **LEGAL GUARDIAN**? ☐ No ☐ Yes
If "Yes," complete the following:

Name: _____ Phone#: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship: ☐ Parent ☐ Child ☐ Sibling ☐ Spouse ☐ Friend ☐ Other (*specify*):

13. DSM-IV Current Diagnoses: Axis I: Primary _____ Secondary _____

Axis II: Primary _____ Secondary _____

Axis III: Related Condition _____

SECTION II: PSYCHOSOCIAL

1. Marital Status: ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single ☐ Unknown

2. Education:

☐ Less than high school ☐ Some high school ☐ High school graduate
☐ Some college ☐ College graduate ☐ Special Education
☐ Unknown

3. Academic skills (check the box which best describes the resident's ~~functional achievements~~):

☐ Yes	☐ No	Can read/recognize simple words
☐ Yes	☐ No	Can read/recognize 3-4 word sentences
☐ Yes	☐ No	Can read at newspaper level (approx. grade 6)
☐ Yes	☐ No	Can perform simple addition/subtraction
☐ Yes	☐ No	Can perform simple multiplication/division

4. Last full-time employment/day program position held:

Name: _____

SECTION II: PSYCHOSOCIAL (*Continued*)

5. **Reasons for admission** (*check all that apply*):

☐ Cannot manage house ☐ Fear for personal safety ☐ Isolation
☐ Convalescent care< 30 days ☐ Financial problems ☐ No primary caregiver
☐ Decline in ADLs ☐ Illness/disease
☐ Emergency placement ☐ Other (*specify*):

6. Is this person able to evacuate a building in 3 minutes unassisted? ☐ No ☐ Yes

7. Provide history to substantiate MR/RC diagnosis:

8. Are there current and ongoing family supports? ☐ No ☐ Yes

Please describe: _____

SECTION III: LEVEL OF FUNCTIONING

1. **Basic Funtional skills**: *Coding 1= Independent 2=Verbal assistance 3=Physical assistance 4= Dependent*

( ) Transferring	( ) Bladder	( ) Bowel	( ) Prepares for bed
( ) Toileting	( ) Self medication	( ) Eating	( ) Dressing/undressing
( ) Bathing	( ) Personal hygiene	( ) Brushing	( ) Selecting appropriate clothes

2. **Advanced Functional skills**: *Coding 1= Independent 2=Verbal assistance 3=Physical assistance 4= Dependent*

( ) Housework	( ) Use of telephone	( ) Use of Money	( ) Goes outdoors safely
( ) Care of clothing	( ) Use of transportation	( ) Manage finances	( ) Treat minor ailments
( ) Meal preparation	( ) Shopping	( ) Use of leisure time	( ) Monitor health status
( ) Employment	( ) Understands time	( ) Respond to emergencies	( ) Attend medical appts.

3. **Cognitive skills:** *Coding 1= Independent 2=Verbal assistance 3=Physical assistance 4= Dependent*

( ) Prepares for daily activities	( ) Understands 1 step instructions	( ) Stays on task
( ) Arranges for transport	( ) Understands multi-step instructions	( ) Completes assignments
( ) Expresses needs and wants	( ) Learns new skills	( ) Transfers skills

4. **Sleep Pattern** (mark one):

☐ Normal ☐ Problems falling asleep ☐ Problems staying asleep ☐ Severely disturbed pattern

Name:

SECTION III: LEVEL OF FUNCTIONING *(Continued*)

5. **Ambulation** (mark one):

☐ Fully independent	☐ Unsteady	☐ Aids (cane/walker/assist. by 1)	☐ Wheelchair/indep.
☐ Wheelchair/assisted	☐ Chairfast or Posey support	☐ Bedfast	☐ Other (*specify)*:

6. **Assistive Devices**: Describe the extent to which corrective/assistive/prosthetic/mechanical devices are used and/or could improve the individual's functional capabilities:

SECTION IV: MEDICAL HISTORY

1. **Psychotropic Medication**
Record any psychotropic medications that have been prescribed and note any changes in dosage in the last three months.

Drug Code/Name	Purpose	Dosage	Freq	Change	Response to Rx

2. **STAT/PRN Administration of Medication**

In the last 60 days, has the individual received an emergency (STAT) or PRN administration of medication to control her/his behavior?

☐ No ☐ Yes

If "yes," please indicate the medication that was administered and the behavior for which the medication was administered:

3. **Physician Review**

Is a physical examination completed and signed by a licensed physician in the last 12 months attached?

☐ Yes, skip, physical examination supplement.
☐ No, the physical examination supplement must be completed and signed by a licensed physician.

4. **Comments**:

5. _____ (____) _____ _____
QMRP Signature Telephone Number Date

Name: _____

SECTION V: BEHAVIORAL ASSESSMENT

1. **Affective Behavior Observations**

a. Physical Features *(mark all that apply):*

- ☐ Clean/Tidy
- ☐ Careless/Dishevelled/Sloppy
- ☐ Makeup or jewelry
- ☐ Non-seasonal clothing
- ☐ Poor hygiene/Unwashed
- ☐ Normal street dress
- ☐ No apparent effort at personal appearance
- ☐ Other *(specify):*_____
- ☐ Well-groomed
- ☐ Wearing bedclothes

b. Level of Consciousness *(mark all that apply):*

☐ Alert ☐ Drowsy ☐ Attentive ☐ Inattentive ☐ Lethargic ☐ Other *(specify):* _____

c. Manner *(mark all that apply):*

☐ Warm ☐ Shy ☐ Threatening ☐ Concerned about others ☐ Outgoing nature ☐ Silly ☐ Sincere ☐ Apathetic ☐ Aggressive ☐ Sense of humor ☐ Suspicious ☐ Easily frustrated ☐ Childlike ☐ Reluctant to Respond ☐ Other *(specify)*: _____

d. Mood and Affect *(mark all that apply):*

- ☐ Appropriate in quality and intensity to stated themes
- ☐ Flat or blunted

☐ Depressed	☐ Mild	☐ Moderate	☐ Severe
☐ Anxious, fearful or worried	☐ Mild	☐ Moderate	☐ Severe
☐ Angry, belligerent or hostile	☐ Mild	☐ Moderate	☐ Severe
☐ Delusional	☐ Mild	☐ Moderate	☐ Severe
☐ Suicidal	☐ Mild	☐ Moderate	☐ Severe
☐ Homicidal	☐ Mild	☐ Moderate	☐ Severe

- ☐ Other *(specify):*_____

e. Form of Thought *(check all that apply):*

☐ Coherent	☐ Incoherent/Illogical	☐ Blocking	☐ Tangentiality
☐ Relevant	☐ Irrelevant/Rambling	☐ Impoverished	☐ Circumstantiality
☐ Logical	☐ Loose Associations	☐ Perseveration	☐ Pressured

f. Orientation Level *(mark one):*

☐ Oriented X3; clear at all times	☐ Oriented X3; forgetful at times	☐ Oriented to person and place
☐ Oriented to person	☐ Oriented to situation	☐ Oriented to bathroom/bed
☐ Confused at times in day	☐ Confused at times at night	☐ Disoriented X3
☐ Nonresponsive	☐ Unable to determine	

g. Communication Ability *(check all that apply):*

☐ No problems	☐ Reads	☐ Writes	☐ Speech unclear/slurred	☐ Gestures/aids
☐ Inappropriate content	☐ Stammer/stutter/impediment		☐ Eye contact	☐ Unresponsive

h. Socialization *(mark all that apply):*

- ☐ Appropriately responds to others' initiations
- ☐ Appropriately initiates contact with others
- ☐ Inappropriate responses/interactions *(describe)*: _____
- ☐ Withdrawn

i. Attitude *(mark one):*

☐ Cooperative ☐ Oppositional ☐ Agitated ☐ Guarded

SECTION V: BEHAVIORAL ASSESSMENT (Continued)

2. **Placement in Seclusion/Physical Restraints/Behavior Changes**

In the last 60 days, has the individual been placed in seclusion or other physical restraints to control dangerous behavior?

☐ No ☐ Yes

If "yes," describe the behavior changes and type of restraints, if applicable: _____

3. **Functional Assessment Summary (ICAP, ABS, etc.)**

Describe current functional status - improvement or decline. Identify any strengths or weaknesses which may impact the individual's participation in specialized services.

a. Motor Skills (This domain assesses one's sensory and motor abilities. Visual and auditory abilities are examined, as are fine-motor and gross motor skills.)

b. Social & Communication Skills (This domain assesses receptive and expressive abilities and how one utilizes those skills to make needs and requests known. This area also assesses the individual's ability to interact with others.)

c. Personal Living (This domain pertains to eating, toileting, maintaining a clean, neat appearance, taking care of clothing, dressing and undressing, etc.)

d. Community Living (This area addresses skills relating to handling money, telling time, acting responsibility, preparing meals, doing laundry, etc.)

e. Broad Independence (This area addresses the individual's overall ability to take care of him/herself and interact in his environment.)

f. Problem Behaviors (Describe any behaviors which are disconcerting or upsetting to others, such as inappropriate physical contact, stereotypical or being overly active. Included in this domain may be behaviors that relate to sexual activity in socially unacceptable ways and behaviors that cause harm to oneself. Describe any behavior strategies that have been implemented and their impact on the behavior.)

SECTION VI: DETERMINATION RECOMMENDATION

1. Name: _____ _____ _____
Last First MI

2. SSN: _____ 3. Medicaid#: _____

4. The individual has, or may have, a diagnosis of mental illness?

☐ No
☐ Yes If yes, specify diagnosis _____

5. Does the individual meet the DSM-IV criteria for mental retardation?

☐ No
☐ Yes, check at least one of the following and substantiate by completing item 6 (include copy of assessment)

☐ Mild ☐ Moderate ☐ Severe ☐ Profound

6. Cognitive test (specify): _____ Date performed: _____

Verbal IQ _____ Perf IQ _____ Full Scale IQ _____

Administered by: _____ Title: _____

7. Does the individual meet the DSM-IV criteria for a related condition?

☐ No, if the answer to question 5 was also no, stop here and sign on page 7.
☐ Yes, check at least one of the following:

☐ Autism	☐ Head Injury	☐ Muscular Dystrophy
☐ Blindness	☐ Hemiparesis	☐ Paraparesis
☐ Cerebral Palsy	☐ Hemiplegia	☐ Paraplegia
☐ Deafness	☐ Hydrocephaly	☐ Polio
☐ Encephalitis	☐ Meningitis	☐ Quadriplegia
☐ Epilepsy/seizures	☐ Microcephaly	☐ Spina Bifida
☐ Friedreich's Ataxia	☐ Multiple Sclerosis	☐ Spinal Cord Injury
☐ Other: (specify) _____		

8. Check the box that best describes the individual's functional level in each of the following areas:

	Independent	Minimal	Moderate	Unable
a. Takes care of most personal needs	☐	☐	☐	☐
b. Understands most simple commands	☐	☐	☐	☐
c. Communicates basic needs and wants	☐	☐	☐	☐
d. Is employed at a productive wage w/o long term supervision/support	☐	☐	☐	☐
e. Learns new skills w/o aggressive and consistent training	☐	☐	☐	☐
f. Generalizes trained skills to other environments w/o aggressive and consistent training	☐	☐	☐	☐

Name: _____

SECTION VI: DETERMINATION RECOMMENDATION

9. SPECIALIZED SERVICES RECOMMENDATION

Does resident require specialized services? ☐ No ☐ Yes **(Mark all that apply):**

CURRENT SPECIALIZED SERVICES		RECOMMENDATIONS		
		Continue	Discontinue	New
☐ 1. Behavior Skills	1.	☐	☐	☐
☐ 2. Communication	2.	☐	☐	☐
☐ 3. Community Living Skills	3.	☐	☐	☐
☐ 4. Resource Utilization Skills	4.	☐	☐	☐
☐ 5. Day Support and Habilitation	5.	☐	☐	☐
☐ 6. Education	6.	☐	☐	☐
☐ 7. Environmental Skills	7.	☐	☐	☐
☐ 8. Pre-Vocational/Sheltered Employment	8.	☐	☐	☐
☐ 9. Self-Advocacy	9.	☐	☐	☐
☐ 10. Self-Help/Personal Care	10.	☐	☐	☐
☐ 11. Social Skills Development	11.	☐	☐	☐
☐ 12. Supported Employment	12.	☐	☐	☐
☐ 13. Task Learning	13.	☐	☐	☐
☐ 14. Transportation to Specialized Services	14.	☐	☐	☐
☐ 15. Assistive Technology Evaluation	15.	☐	☐	☐
☐ 16. Assistive Technology	16.	☐	☐	☐
☐ 16a. Communication devices	16a.	☐	☐	☐
☐ 16b. Compensatory devices	16b.	☐	☐	☐
☐ 16c. Environmental control devices	16c.	☐	☐	☐
☐ 16d. Environmental modifications	16d.	☐	☐	☐
☐ 16e. Feeding devices	16e.	☐	☐	☐
☐ 16f. Wheelchair Seating/positioning	16f.	☐	☐	☐
☐ 16g. Wheelchair fitting-customized	16g.	☐	☐	☐
☐ 16h. Mobility aids	16h.	☐	☐	☐
☐ 17. Other adaptive devices (specify):_____	17.	☐	☐	☐

Rationale: _____

_____

_____

10. SERVICES OF LESSER INTENSITY

Does resident require services of lesser intensity? ☐ NO ☐ YES **(Mark all that apply)**

- ☐ 1. Adjustment needs
- ☐ 2. Basic grooming
- ☐ 3. Behavior management
- ☐ 4. Non-customized durable medical equipment
- ☐ 5. Occupational therapy
- ☐ 6. Physical therapy
- ☐ 7. Restorative nursing
- ☐ 8. Speech-language pathology
- ☐ 9. Sensory stimulation
- ☐ 10. Visual/Hearing
- ☐ 11. Other _____

11. Print Assessor's Name _____ Title _____ Telephone (___) _____

Assessor/QMRP Signature _____ Date: _____